LETTERS *to the Editor*

Early and Periodic Screening

TO THE EDITOR: ". . . activism without rationality, even for the noblest ideals may exploit those with the greatest problems. Funds to meet the needs of children must not be dissipated by useless screening" (Gershman M: Position on early and periodic screening (Letter to the Editor). West J Med 121:69, Jul 1974).

Right on!

I know of no practicing physician more experienced or enthusiastic about preventive examinations than myself, with about 20,000 in 20 years (4 daily) complete from diet diary and emotional evaluation of children to tonometry and sigmoidoscopy of adults over 35. Obviously, my patients and I find my examinations very productive or we would not continue them. However, I, too, would urge your readers to oppose implementation of Brown Bill AB 2068, now Chapter 1069 of the Health and Safety Code, financing health screening for Medicaid eligibles under age 21.

If politicians had done their homework (and cared about results) they would have learned from numerous studies that:

(1) The likelihood of eliciting significant health problems is much less when done in mass production than when done by the personal physician;

(2) The cost of such services is far greater when done by bureaucracy instead of fee-for-service physicians—even with competition as diluted as it is by (a) organization opposition to public information on prices and, (b) by third party payment minimizing motivation for thrift;

(3) Follow-up action on defects detected in mass screening is relatively poor, compared with correction of health deficiencies found by the family doctor.

References range from the Pennsylvania studies of the '50s (which portrayed the frustration of finding the prevalent tooth decay, occasional significant heart murmurs, etc., which were generally untreated years after discovery), to readers' own recent experience with hard-to-read computer print-outs from the Cannery Workers, to the family doctor largely duplicating Palo Alto Clinic "executive examinations," in order to properly treat his ulcer patient.

"Doctor" comes from Latin "docere" meaning "to teach." An effective personal physician spends most of his time eliciting learning. He and his aides have much better opportunity than strange clerk, piece of paper, or even Public Health nurse to adequately motivate a wheezy smoker, fat diabetic, type A hypercholesterolemic, asymptomatic rectal polyp owner, or oppressive parent.

Shall we merely establish another of the Editor's well-noted "adversary relationships" against government, where "tragically, once again it will be the patients who will inevitably bear the brunt"? Or shall we fulfill the need for personal physicians' comprehensive periodic health evaluations (yearly checkups)?

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Nocardia Asteroides Infections

TO THE EDITOR: In the recent report by Epstein [Epstein E: Treatment of cutaneous Nocardia asteroides infection with minocycline hydrochloride. West J Med 120:497-499, Jun 1974] of a patient with infection due to Nocardia asteroides, there are three assumptions that should not pass unchallenged, namely, that the infection in the patient presented was limited to the skin, that there is evidence that minocycline is effective in the treatment of nocardiosis, and that 77 days of therapy is an "extended" course for this infection.

There is little doubt that a normal chest x-ray does not rule out disseminated nocardiosis. A nocardial brain abscess and an abscess of the psoas muscle—improbable sites for direct inoculation of the organism—have been reported in two patients in whom there was no evidence of pulmonary involvement.[1] We have recently seen two heart transplant patients who also illustrate this point.[2] In one patient with nocardial subcutaneous abscesses, chest x-ray revealed a very small lesion

(possibly due to Nocardia) which, in retrospect, had been present one month earlier. The other patient died and at autopsy was found to have a small pulmonary nocardial abscess that had been clinically and roentgenographically inapparent. We consider the possibility that the patient whose metastatic skin abscess has become clinically apparent might also have a nocardial lesion growing silently in the brain.

Sulfonamides are the "classic agents" for treating nocardiosis because they are extremely effective in the great majority of patients who are not moribund due to one or more brain abscesses. However, there are patients who cannot take sulfonamides or in whom the infection does not appear to be responding to these agents. It is primarily for these reasons, as clearly stated by Bach et al,[3] that their recent paper describing the use of drugs other than sulfonamides in two patients with nocardiosis is important. In the patient of Bach et al, sputum culture became positive within 48 hours after discontinuing a two-month course of minocycline, and when the patient died from unrelated causes after another five-to-six week course of minocycline, sections of lung at autopsy disclosed organisms compatible with Nocardia. The patient described in the other paper[4] cited by Epstein had a pulmonary nocardial lesion that stabilized on nine days of intravenous sulfisoxasole therapy. Since sulfisoxasole was not discontinued when minocycline was begun, and since it is not unreasonable to expect a cavitary nocardial lesion to take more than nine days to regress, the contribution of minocycline to the course of this patient's nocardiosis is moot. We find it difficult to accept these two published cases as evidence that minocycline is effective as the sole antimicrobial therapy for nocardiosis. However, the patient of Bach et al and Epstein's patient do constitute a small amount of evidence that minocycline may be effective in the short-term suppression of this infection. Because of the proven efficacy of sulfonamides in treating this infection, we believe that the latter antimicrobial agents remain the drugs of choice for nocardiosis.

The duration of therapy necessary to eradicate a nocardial infection is not known, but relapses have occurred often enough that the importance of treatment up to or even longer than a year has become apparent.[1,5] A healthy respect for the ability of this organism to "play possum" may be acquired from the report of a patient who was in his fifth month of sulfonamide therapy for nocardial subcutaneous abscesses when he developed clinically apparent multiple nocardial brain abscesses.[6] Although it is possible that Epstein's patient was "cured" by a two and one-half month course of minocycline, such a course of therapy is not to be considered as being "extended" in the treatment of this infection. Long-term follow-up information on his patient will be of great interest.

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REFERENCES

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5. Pinkhas J, Oliver I, deVries A, et al: Pulmonary nocardiosis complicating malignant lymphoma successfully treated with chemotherapy. Chest 63:367-370, 1973
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The Author Replies

I FIND IT DIFFICULT to understand the criticisms raised by Drs. Krick and Remington. All that this article intended to do was to briefly present the case of a man on immunosuppressive therapy who developed an abscess on his leg due to N. asteroides and which cleared with the oral administration of minocycline hydrochloride. These correspondents list three objections to the presentation all of which seem to be answered in this less than monographic article.

First, they deny that the infection in this patient was limited to the skin. The only statement in this regard is, "There was no evidence of nocardial involvement of any system other than the skin." It is admitted in the article that, "Usually the lungs are the site of infection, but other organs—the skin, for example—may be involved either by dissemination or by direct primary infection." I have no evidence that any system other than the cutaneous one was involved. Perhaps Krick and Remington have more divine guidance than I do.

Secondly, they express doubt that minocycline hydrochloride is effective in nocardiosis. The article quotes a number of other investigators who agree that this agent is of benefit in controlling this infection. No one denies the efficacy of sul-